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Toward Sexual Health Equity for Gay, Bisexual, and Transgender Youth: An Intergenerational, Collaborative, Multisector Partnerships Approach to Structural Change

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Abstract

Background. Gay, bisexual, and transgender youth (GBTY) experience sexual health inequities and contend with intersectional oppression. The Michigan Forward in Enhancing Research and Community Equity (MFierce) Coalition formed as an intergenerational, collaborative, multisector partnership with a focus on implementing community-identified policy, systems, and environmental (PSE) change strategies to address inequities and injustices. *Aims.* We describe MFierce coalition development and structural change activities organized within Collaborating for Equity and Justice (CEJ) principles and provide empirical data supporting the utility of such principles. *Method.* We prioritized leadership by GBTY and created personal and professional capacity-building activities to support GBTY in being change agents. Our work was grounded in community-engaged scholarship and used a shared-power community development process. Our PSE change intervention, the Health Access Initiative (HAI), was a structural change program for health facilities aimed at improving the quality of and access to sexual health care for GBTY. *Results.* We evaluated coalition functioning and activities through multimethod assessments and evaluated PSE changes through HAI participant surveys. Data demonstrated positive and steady coalition dynamics, multiple benefits of participation for GBTY, and strategies for collaborative multigenerational community work. HAI outcome data revealed significant increases in PSE changes. *Discussion.* Centering life experiences of GBTY in collaborative partnerships and building opportunities for professional and personal development can support sustainable community change. We offer recommendations for developing future intergenerational, collaborative, multisector partnerships that prioritize youth leadership. *Conclusion.* Collaborative methods and careful consideration of adult–youth dynamics can inform future transformative efforts focused on health equity and justice for GBTY.

Keywords

community-based participatory research, community coalition, health equity, sexual and gender minorities, sexual health, structural change

Coalition building, community organizing, and policy, systems, and environmental (PSE) change strategies are effective in addressing health inequities (Israel, Eng, Schulz, & Parker, 2012; Minkler, 2012). Decades of research has illustrated the value and importance of using collaborative processes to address historical injustices (Israel, Schulz, Parker, & Becker, 1998; Schulz, Krieger, & Galea, 2002; Wallerstein & Duran, 2006). The creation of community coalitions allows stakeholders to assess community needs, share their perspectives, and actively shape and participate in the

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development, implementation, and evaluation of social change interventions (Eng & Blanchard, 2006; Harper, Contreras, Bangi, & Pedraza, 2003; Robles-Schrader et al., 2012; Suarez-Balcazar & Harper, 2003; Ziff et al., 2006). Health-focused coalitions have demonstrated that participatory processes are effective in addressing historical and systemic barriers to health promotion and in designing effective community-determined solutions (Harper et al., 2004; Israel et al., 2010; Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001).

Recognizing that marginalized groups in the United States face tremendous structural inequities, Wolff et al. (2017) issued a call to action for future coalitions and collaborations to explicitly focus on equity and justice. They developed Collaborating for Equity and Justice (CEJ) principles to establish "new ways to engage our communities in collaborative action that will lead to transformative changes in power, equity, and justice" (Wolff et al., 2017, pp. 49-50). Their approach prioritizes leadership by those most affected by injustice and inequity in order to create sustainable community change.

Sexually transmitted infections (STIs), including HIV, have disproportionately affected gay, bisexual, and transgender youth (GBTY), with inequities accentuated among racial/ethnic minority GBTY (Centers for Disease Control, 2018a, 2018b). Research has connected these disproportionate rates of STIs to increased exposure to negative social determinants of health, such as racism, poverty, and stigma (Bauermeister, Eaton, et al., 2015; Bauermeister, Goldenberg, Connochie, Jadwin-Cakmak, & Stephenson, 2016; Dean & Fenton, 2013). Although community coalitions, community mobilization, and PSE change efforts have been recognized as valuable approaches to addressing STI and HIV inequities among youth (Alcantara, Harper, & Keys, 2015; Harper et al., 2004; Ziff et al., 2006), current rates of HIV/STIs demonstrate a need for more targeted efforts.

HIV/STI disparities occur along multiple minority social identities (e.g., sexual and gender minorities, ethnic/racial minorities, youth) that have historically experienced layers of injustice and powerlessness in the United States (Centers for Disease Control, 2018a, 2018b; Harper & Wilson, 2016; Wolitski & Fenton, 2011). Therefore, strategies to promote sexual health equity must incorporate intersectional frameworks to address how individuals belonging to multiple minority groups face an amplification of vulnerability (Bowleg, Teti, Malebranche, & Tschann, 2013; Reed & Miller, 2016; Wilson & Harper, 2013). Such frameworks posit that the ways in which various social identities are positioned reveal structural-level relationships among systems of oppression and injustices like racism and sexism (Bowleg, 2013; Crenshaw, 1989). Effective community mobilization for health equity must identify and address structural inequities in order to respond to the specific needs of stigmatized and marginalized communities (Harper, 2007; Robles-Schrader et al., 2012).

The Michigan Forward in Enhancing Research and Community Equity (MFierce) Coalition formed as an intergenerational, collaborative, multisector partnership of public health practitioners and researchers, community-based organizations, health departments, and GBTY (Bauermeister et al., 2017). MFierce's geographic area of focus—Southeast Michigan—included the Metro Detroit and greater Flint areas, where structural inequities (e.g., poverty, housing instability) and HIV/STI rates disproportionately experienced by GBTY remain high (Bauermeister, Eaton, et al., 2015). Funded through the Centers for Disease Control and Prevention's Community Approaches to Reducing Sexually Transmitted Diseases 3-year cooperative agreement, MFierce was tasked with using participatory methods to implement community-identified PSE change strategies to respond to disproportionately high rates of HIV/STIs among GBTY.

Our coalition activities utilized Wolff et al.'s (2017) CEJ principles for collaborative practice. In this article, we describe coalition development and activities organized within four sets of CEJ principles. Next, we present evaluation data from surveys, interviews, and ripple effect mapping focused on coalition development and functioning, followed by survey evaluation data focused on PSE changes. We end with recommendations for developing and maintaining intergenerational, collaborative, multisector partnerships that prioritize leadership by youth who are most affected by injustice and inequity.

Method

Building Resident Leadership and Constructing Core Functions Based on Equity and Justice

The MFierce coalition utilized CEJ principles in its organizational structure and functioning. Consistent with Principle 6 (i.e., encouraging collaborations to develop well-defined core functions for members based on equity and justice, and encouraging developing community member ownership and leadership), the MFierce coalition was an intergenerational, collaborative, multisector partnership that prioritized leadership by youth who are most affected by sexual health injustice and inequity. It was composed of three entities: A University Team (University), a Youth Advisory Board (YAB), and a Steering Committee.

The University was the convening group and consisted of public health researchers and practitioners with expertise in community organizing, community psychology, public health, and adolescent development. The Steering Committee included representatives from various sectors that provide sexual health–related services to GBTY (i.e., community-based organizations and city and state health departments). The YAB included eight GBTY, ages 19 to 29 years, from Southeast Michigan who were hired as University employees. While hours varied per week, YAB members began working up to 12 hours per week, with some increasing to full time

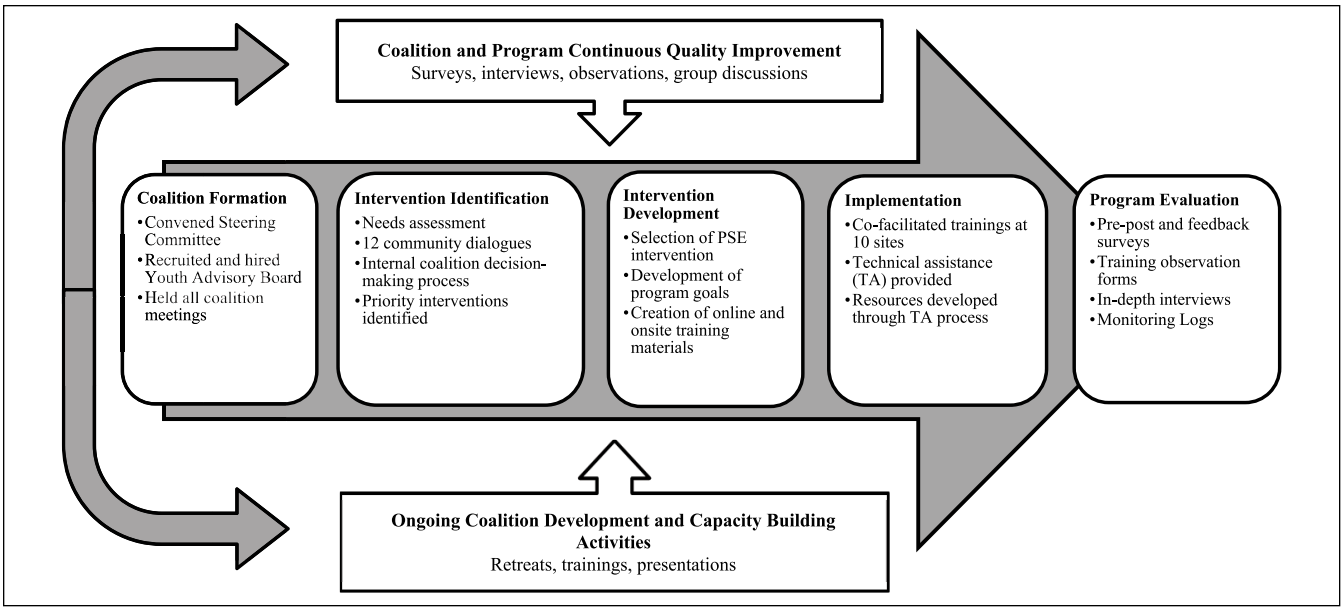

Figure 1. MFierce youth-centered participatory program development model.
Note. PSE = policy, system, and environmental.

over the course of the project. Since our approach prioritized leadership from GBTY community residents, we created personal and professional capacity-building activities to ensure they would have the capabilities to be active change agents for their communities. During YAB meetings and professional development trainings, we also facilitated critical discussions regarding the role of oppression in health equity for GBTY. These dialogues were grounded in an intersectional framework, whereby YAB members explored how multiple social identities intersect and influence one another, resulting in complex experiences of oppression and privilege.

The CEJ Principle 3 encourages collaborations to incorporate community organizing into their process and strategy and to enhance the power of community residents who are most affected by an issue to hold leadership positions and advance community-driven solutions. Coalition entities met separately and jointly throughout the project, with YAB members meeting on a weekly to biweekly basis with the University. MFierce used annual all-coalition retreats to build relationships, provide updates, and complete critical tasks. We also created internal capacity-building programs for YAB members, which included a summer internship program where YAB members were paid to spend 30 hours per week at specific Steering Committee sites and a job shadow day. These activities were designed to increase both bonding and bridging social capital by creating spaces for both YAB and Steering Committee members to network and build capacity within their unique homogenous groups, as well as to connect across groups in order to share information, ideas, and support (Kim, Subramanian, & Kawachi, 2006).

Members of the coalition were actively engaged in developing and enacting all phases of the youth-centered participatory program development model created for this project (see Figure 1). Members also participated in ongoing coalition development and capacity-building activities, as well as coalition and program continuous quality improvement.

Building on Community-Engaged Scholarship and Research

The CEJ Principle 5 encourages partnerships to build on the current extensive community-engaged scholarship and research base, drawing from empirical and theoretical work that acknowledges the complexity of partnership work and demonstrates its effectiveness. The formation and maintenance of the MFierce coalition and its resulting PSE change activities utilized principles and methods from community-based participatory research (Israel et al., 2012), community coalition action theory (Butterfoss & Kegler, 2009), and the interactive and contextual model of collaboration (Suarez-Balcazar, Harper, & Lewis, 2005). Since many coalition members participated in prior local and national youth-centered community mobilization efforts, we leveraged best practices and lessons learned from the United for HIV Integration and Policy project (Bauermeister, Eaton, et al., 2015), the Get Connected! intervention (Bauermeister, Pingel, et al., 2015), and Connect to Protect (Harper, Willard, Ellen, & Adolescent Medicine Trials Network, 2012).

The coalition scheduled multiple activities (e.g., retreats, conference presentations, and professional development) to build the capacity of members as active participants in creating and sharing community-engaged scholarship. Although various entities within the coalition participated in this, we privileged scholarship capacity building within the YAB so that GBTY could not only participate in the dissemination of scholarship aimed at creating positive change in communities

but also lead such efforts. Throughout the project, YAB members completed 26 trainings on topics including advocacy, leadership, presentation skills, sexual health, and digital media. They also provided presentations on GBTY health for medical and social service providers at 10 different regional and national professional conferences. Additional members of the coalition also disseminated community-engaged scholarship at four national conferences.

Employing a Shared-Power Community Development Process

The CEJ Principle 2 encourages partnerships to use a community development approach where community members have equal power in determining the coalition's agenda and resource allocation. They recommend the use of strategies to engage community members in ways that are attentive to power dynamics, especially for those who experience injustice. The mandate of the funding initiative was to develop community-engaged initiatives intended to create policies, systems, and environments that were supportive of sexual health equity. Coalition members conducted a series of 12 community dialogue sessions across Southeast Michigan to promote shared-power and decision-making regarding the identification of the PSE change intervention the coalition would develop and implement. These sessions were co-facilitated by YAB, Steering Committee, and University members and involved activities designed to reduce power imbalances and generate ideas for potential PSE change interventions. Participants included noncoalition members of the priority community (GBTY) and individuals from organizations dedicated to sexual health equity for youth. See Bauermeister et al. (2017) for additional information on our community dialogue process and evaluation.

Once potential interventions were identified, the coalition entered an internal decision-making process. We created small groups with at least one YAB, Steering Committee, and University member in order to further explore and develop an overview of potential PSE change interventions. Meeting separately, each group created a logic model, basic budget, and feasibility assessment for their specific intervention. In an all-coalition meeting, individuals presented and discussed their PSE change intervention proposals. Members then voted to select the intervention that would be the focus of the coalition's activities.

Focusing on Policy, Systems, and Structural Change

The CEJ Principle 4 encourages partnerships to move beyond the programmatic level and focus on policies, systems, and structural changes that are needed to have sustained impact on communities experiencing injustice and inequities. The PSE change intervention selected through our shared decision-making process was the Health Access Initiative (HAI), a structural change intervention for health clinics in Southeast Michigan to improve the quality of and access to sexual health care for GBTY. The HAI included online and on-site intervention sessions as well as individualized technical assistance (TA) for participating sites. It focused on improving staff members' cultural humility practices with GBTY by encouraging critical reflection, intersectional examinations of power dynamics, and lifelong learning to develop respectful partnerships with clients (Hook, Davis, Owen, Worthington, & Utsey, 2013; Tervalon & Murray-Garcia, 1998). We provided additional resources for improving cultural humility practices and PSE changes through our TA activities. Through dialogue and consensus decision making in large and small group meetings, YAB, Steering Committee, and University members collaboratively decided on the intervention training topics and codeveloped the training content. The facilitator guide and participant book were collectively reviewed and edited by the coalition.

The HAI was implemented at 10 sites including health departments, community health centers, youth-specific health centers, a school-based health clinic, a pediatric clinic, and a center for those living with or vulnerable to HIV. Twenty-six sites applied; however, due to capacity restrictions, only 10 were selected. To participate, sites had to offer HIV and STI testing and serve (though not exclusively) GBTY between the ages of 15 and 29 years. Sites were followed for 6 months postintervention, and given baseline, 3-month, and 6-month assessments. Given the focus on changing each clinic's system, all employees were encouraged to participate regardless of their role within the facility. The 1-hour online training featured YAB members' testimonies on culturally humble GBTY care. Two medical providers were contracted to co-facilitate the 2-hour on-site trainings alongside a University member and a YAB member. Additional YAB members attended the HAI trainings to partake in a question and answer session.

We provided TA to each site for 3 months after their on-site training. YAB members worked closely with the University team to create 31 digital and print resources and provided TA including support with patient intake forms, signage, program development, resources on GBTY sexual health and creating inclusive environments, and referrals to external resources or organizations. All created resources are publicly available at www.mfierce.org.

Conducting Multimethod Evaluations of Coalition and HAI Processes and Outcomes

Coalition Evaluations. We evaluated coalition and HAI functioning and activities through multimethod assessments. The YAB completed online feedback surveys after professional development trainings, the summer internship, and the job shadow to assess and improve these activities. Over 3 years, coalition members (YAB, Steering Committee, University) completed an online biannual partnership survey that

assessed several coalition domains in order to assess and improve coalition structure and functioning. For the purposes of this article, we focus on domains related to CEJ principles: (1) Mutual Respect, Understanding, and Trust; (2) Open and Frequent Communication; (3) Ability to Compromise; (4) Shared Stake in Process and Outcomes; and (5) Flexibility. In Years 1 and 2, we developed items from these domains from a literature review of coalition evaluation metrics appropriate for newly formed partnerships. By Year 3, we used the shorter Wilder Collaborations Factors Inventory (Mattessich, Murray-Close, & Monsey, 2001) to measure these domains, as it was more appropriate for the now established coalition. We computed measures of central tendency (mean, standard deviation, and median) for each coalition domain assessed (see Table 1), and examined whether there were mean differences over times across the coalition scores using a one-way repeated measures ANOVA.

We supplemented these quantitative coalition assessments with in-depth interviews with the YAB and Steering Committee in Years 1 ($n = 18$) and 2 ($n = 12$). Qualitative interviews were content analyzed to provide deeper insight into and feedback on their experiences. At the final all-coalition retreat, we used ripple effect mapping to understand the intended and unintended effects of the overall project using appreciative inquiry, storytelling, and collective mapping (Emery, Higgins, Chazdon, & Hansen, 2015; Kollock, Flage, Chazdon, Paine, & Higgins, 2012). We transcribed the illustrated map into text and then thematically analyzed these data. Qualitative data from interviews, surveys, and ripple effect mapping are found in Figure 2.

HAI Intervention Evaluations. Continuous quality improvement assessments occurred throughout the delivery of the HAI intervention. HAI participants completed satisfaction surveys immediately after online and onsite intervention activities, and we used these data to make modifications to the onsite activities. In addition, members of the coalition provided additional feedback in order to improve the HAI by conducting semistructured observations of the in-person sessions and then providing direct feedback and recommendations to facilitators.

In Year 3, we evaluated the HAI intervention effects through baseline, 3-month, and 6-month post surveys that measured changes in policies, practices, and environments at the sites. Responses from agency staff were aggregated into agency-level scores. Given the small sample size ($n = 10$ agencies), we used the Wilcoxon matched-pair signed-rank test to examine differences in proportions (yes vs. no/unsure) between baseline and 6-month follow-up (see Table 2). We then estimated effect sizes (r) for the observed changes as derived from Rosenthal (1994), where $r \leq .10$ is described as a small effect size, $r > .10$ and $\leq .30$ is described as a moderate effect size, and $r \geq .50$ indicates a large effect size. We also conducted post-TA qualitative interviews with site liaisons to obtain a deeper understanding of the PSE changes and quality of the TA process.

Results

MFierce Coalition Processes

The partnership surveys revealed that the five coalition functioning domains that were in alignment with CEJ principles were high and remained stable over time among all members (see Table 1). Results from our repeated-measures one-way ANOVAs indicated that there were no statistically significant changes over time in coalition functioning.

Since our coalition prioritized leadership of GBTY, the remainder of the coalition processes data will focus on the YAB and are based on a triangulation of data from in-depth interviews, YAB feedback surveys, meeting discussion notes, and ripple effect mapping (see Figure 2). These sources revealed that YAB members reported experiencing multiple domains of benefits from their participation. Quotes from in-depth interviews and open-ended survey items illuminated these three domains: (1) gaining and enhancing skills; (2) receiving opportunities to network, grow relationships, and develop personally and professionally; and (3) developing a sense of ownership, influence, and leadership. YAB members believed that activities, like facilitating community dialogues and offering conference presentations, helped them feel recognized as experts and community leaders.

The data identified facilitators to YAB participation in the coalition, which included compensation of hourly pay, meals and snacks, parking and transportation stipends, and sponsorship for conferences. Additional facilitators included increased skills; access to professional growth; and feeling highly engaged, empowered, and like they "had a voice" in the process.

The data illuminated changes in YAB members' life circumstances as a main barrier to participating in the project. Many YAB members faced hardships in their personal lives, including economic instability, mental health issues, and food insecurity. This, coupled with limited transportation and changes in availability, made it difficult for some YAB members to attend meetings or remain engaged in the project altogether. Many members openly shared these challenges and felt the YAB was one of the safer places for them to discuss these issues, which reduced feelings of isolation.

The evaluation data also revealed some challenges. YAB members experienced role ambiguity and felt that transparency was limited in some decision-making processes. Most YAB members worked fewer than 10 hours per week, which made it difficult to involve them in all decisions and project coordination. The University made further efforts to build trust and provide more updates and information on why and how decisions were made. With the shift to HAI implementation, YAB members' roles and responsibilities increased.

Table 1. MFierce Coalition Dynamics Over Time as Reported by University Team, Youth Advisory Board, and Steering Committee.

	Year 1, *M* (*SD*)/*Mdn*		Year 2, *M* (*SD*)/*Mdn*		Year 3, *M* (*SD*)/*Mdn*	
Item	March 2015 (*N* = 24)	September 2015 (*N* = 25)	March 2016 (*N* = 21)	September 2016 (*N* = 18)	March 2017 (*N* = 14)	September 2017 (*N* = 10)
Factor 1: Mutual Respect, Understanding, and Trust						
I feel safe sharing my thoughts with partners.	4.42 (0.58)/4	4.20 (0.76)/4	4.21 (1.03)/4	3.93 (0.70)/4		
Partners respect my thoughts, feelings, and opinions.	4.54 (0.51)/5	4.48 (0.59)/5	4.21 (0.92)/4	4.27 (0.70)/4		
People involved in our collaboration always trust one another.					3.36 (1.15)/3	4.10 (0.88)/4
I have a lot of respect for the other people involved in this collaboration.					4.50 (0.52)/4.5	4.60 (0.70)/5
Average score	4.48 (0.44)/4.5	4.34 (0.62)/4	4.21 (0.93)/4.5	4.10 (0.57)/4	3.93 (0.73)/4	4.35 (0.74)/4.5
Factor 2: Open and Frequent Communication						
I am informed about meeting locations and time well in advance.	4.29 (0.81)/4	4.48 (0.51)/4	4.58 (0.77)/5	4.53 (0.52)/5		
Decisions are made with input from all partners.	4.25 (0.74)/4	4.04 (0.68)/4	3.95 (1.27)/4	4.20 (0.86)/4		
There is open communication between all partners.	3.75 (0.94)/4	3.84 (1.03)/4	4.00 (1.00)/4	3.47 (0.83)/4		
People in this collaboration communicate openly with one another.					3.86 (1.03)/4	4.40 (0.97)/5
I am informed as often as I should be about what goes on in the collaboration.					4.21 (0.89)/4	4.40 (0.52)/4
The people who lead this collaborative group communicate well with the members.					3.71 (1.20)/4	4.20 (0.63)/4
Average score	4.10 (0.67)/4	4.12 (0.58)/4.33	4.18 (0.91)/4.33	4.07 (0.49)/4	3.93 (0.88)/4	4.33 (0.59)/4.33
Factor 3: Ability to Compromise						
Disagreements between partners are resolved appropriately and respectfully.	4.00 (0.83)/4	3.88 (0.80)/4	4.11 (0.94)/4	4.13 (0.74)/4		
People involved in our collaboration are willing to compromise on important aspects of our project.					3.64 (1.01)/4	4.10 (0.74)/4
Average score	4.00 (0.83)/4	3.88 (0.80)/4	4.11 (0.94)/4	4.13 (0.74)/4	3.64 (1.01)/4	4.10 (0.74)/4

(continued)

Table 1. (continued)

Item	Year 1, *M* (*SD*)/*Mdn*		Year 2, *M* (*SD*)/*Mdn*		Year 3, *M* (*SD*)/*Mdn*	
	March 2015 (*N* = 24)	September 2015 (*N* = 25)	March 2016 (*N* = 21)	September 2016 (*N* = 18)	March 2017 (*N* = 14)	September 2017 (*N* = 10)
Factor 4: Members Share a Stake in Both Process and Outcome						
Other partners demonstrate commitment to the MFierce goals.	4.42 (0.50)/4	4.32 (0.56)/4	4.21 (0.72)/4	4.60 (0.51)/5		
Partners care about the communities MFierce seeks to impact.	4.79 (0.42)/5	4.60 (0.50)/5	4.32 (1.00)/5	4.67 (0.49)/5		
The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.					4.14 (0.54)/4	4.20 (0.79)/4
Everyone who is a member of our collaborative group wants this project to succeed.					4.86 (0.36)/5	4.80 (0.42)/5
The level of commitment among the collaboration participants is high.					3.79 (0.89)/4	3.90 (0.74)/4
Average score	4.60 (0.39)/4.5	4.46 (0.48)/4.5	4.26 (0.81)/4.5	4.66 (0.44)/5	4.26 (0.51)/4.33	4.30 (0.51)/4.33
Factor 5: Flexibility						
Partners are open to different points of view.	4.25 (0.61)/4	4.32 (0.69)/4	4.16 (1.02)/4	4.20 (0.68)/4		
Even when I miss partner meetings, I am kept informed about the progress of the project.	4.21 (0.93)/4	3.92 (0.64)/4	4.11 (0.94)/4	3.80 (0.94)/4		
There is a lot of flexibility when decisions are made; people are open to discussing different options.					4.00 (0.96)/4	4.20 (0.63)/4
People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.					4.21 (0.58)/4	4.30 (0.68)/4
Average score	4.23 (0.51)/4	4.06 (0.65)/4	4.11 (0.95)/4	4.07 (0.73)/4	4.11 (0.71)/4	4.25 (0.63)/4

Note. Items were answered on a 5-point scale (1 = *strongly disagree*; 3 = *neutral*; 5 = *strongly agree*).

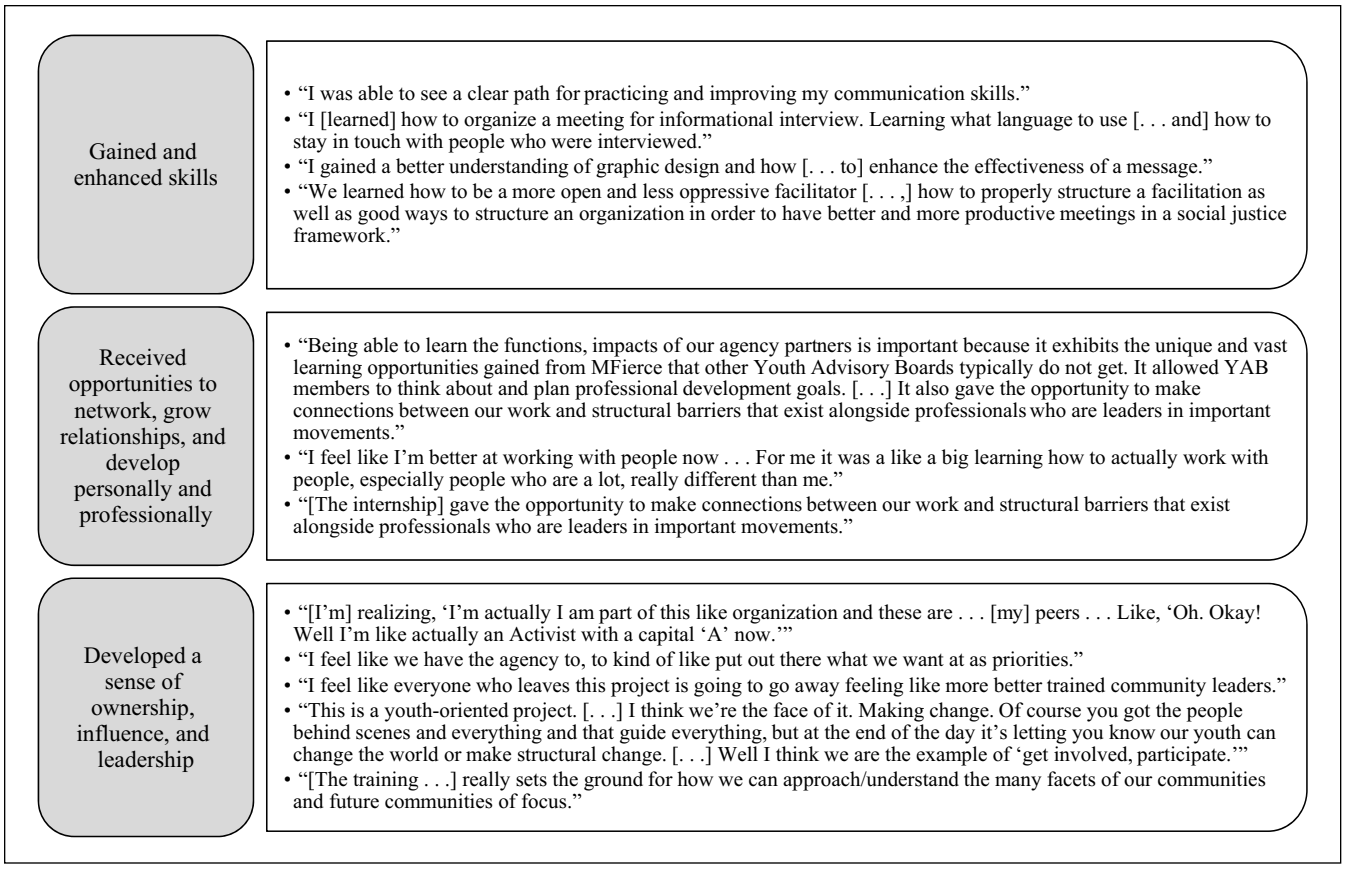

Figure 2. Benefits of employing a youth-centered participatory program development model.
Note. Domains of benefits were created from thematic analysis of in-depth interviews, training feedback surveys, and ripple effect mapping. Quotes are from in-depth interviews and open-ended survey responses. MFierce = Michigan Forward in Enhancing Research and Community Equity; YAB = Youth Advisory Board.

Many YAB members welcomed the expansion of responsibilities, while others did not. Year 2 interviews and ripple effect mapping also echoed this dynamic: Their contributions increased over time, but it was more difficult for YAB members to understand their duties as they moved into roles similar to program assistants.

MFierce Coalition Outcomes: Achieving PSE Change

Members of the YAB and the University implemented the HAI intervention, which consisted of 1-hour online training ($n = 101$) and a 2-hour onsite training ($n = 152$) at the 10 sites. Feedback surveys revealed both intervention trainings were useful and received well.

Fifteen survey items examined PSE changes at sites including policies, procedures, and environmental factors, with all PSE items demonstrating statistically significant improvements at 6 months (see Table 2). These PSE changes included making improvements to electronic medical records, availability of educational materials specifically for GBTY, inclusive clinic environments, and comprehensive nondiscrimination policies. Post-TA interviews with site liaisons also revealed that PSE changes occurred (or were in process) and that the TA was useful in supporting those changes. Each site received an average of 209 resources and referrals.

Discussion

Limitations

The coalition experienced several challenges including significant barriers to participation, which affected the retention of YAB members. In addition, qualitative data analysis illustrates that power sharing and communication around decision making could have been improved. Furthermore, some YAB members did not embrace additional responsibility over time. This sometimes led to feelings of dissatisfaction that could have been addressed more thoroughly by the University team. While the YAB lost some members, participation among the remaining members remained consistent.

Recognizing and acknowledging the complexity of collaborative partnerships is essential. Using participatory methods requires more time than less engaged methods due to the greater number of people and the more intensive involvement of each person. It is challenging to develop, implement, and evaluate a participatory community change project that

Table 2. Policy, Systems, and Environmental Changes Among 10 Clinics Served Through the Health Access Initiative.

	Baseline, *n* (%)		6 months post intervention, *n* (%)			
Item	Yes	No/unsure	Yes	No/unsure	Effect size (*r*)	*p* value
Our clinic has made changes to our EMR (electronic medical record) or paper records to document patients' . . .						
. . . preferred names	5 (50.0%)	5 (50.0%)	10 (100%)	0 (0%)	.71	.03
. . . preferred pronouns	3 (30.0%)	7 (70.0%)	8 (80.0%)	2 (20.0%)	.71	.03
. . . gender identity	6 (60.0%)	4 (40.0%)	9 (90.0%)	1 (10.0%)	.55	.08
. . . sexual orientation	3 (30.0%)	7 (70.0%)	7 (70.0%)	3 (30.0%)	.45	.16
Our clinic has educational materials specifically tailored for . . .						
. . . gay or bisexual young men	6 (60.0%)	4 (40.0%)	8 (80.0%)	2 (20.0%)	.45	.16
. . . transgender and gender nonconforming youth	3 (30.0%)	7 (70.0%)	8 (80.0%)	2 (20.0%)	.71	.03
Our clinic has a referral list that includes resources for. . .						
. . . gay and bisexual young men	5 (50.0%)	5 (50.0%)	9 (90.0%)	1 (10.0%)	.63	.04
. . . transgender and gender nonconforming youth	3 (30.0%)	7 (70.0%)	9 (90.0%)	1 (10.0%)	.77	.01
Our clinic has affirming posters for LGBTQ+ youth	7 (70.0%)	3 (30.0%)	9 (90.0%)	1 (10.0%)	.45	.16
Our clinic has a policy that allows all people to use the restroom that is consistent with their gender identity	4 (40.0%)	6 (60.0%)	7 (70.0%)	3 (30.0%)	.42	.18
Our clinic has a single occupancy restroom that is gender neutral or unisex	9 (90.0%)	1 (10.0%)	9 (90.0%)	1 (10.0%)	0	1
Overall, I think our clinic is a safe space for. . .						
. . . gay and bisexual young men	10 (100%)	0 (0%)	10 (100.0%)	0 (0%)	0	1
. . . gender nonconforming youth	10 (100%)	0 (0%)	10 (100.0%)	0 (0%)	0	1
Our clinic has a non- discrimination policy that includes. . .						
. . . gender identity and gender expression	9 (90.0%)	1 (10.0%)	10 (100.0%)	0 (0%)	.32	.32
. . . sexual orientation	10 (100%)	0 (0%)	10 (100.0%)	0 (0%)	0	1

Note. Given small sample sizes, the Wilcoxon matched-pair signed-rank test was employed to examine differences in proportions between baseline and 6-month follow-up. Reported *p* values are asymptomatic. Effect sizes (*r*) are derived from Rosenthal (1994), where $r \leq .10$ is described as a small effect size, $r > .10$ and $\leq .30$ is described as a moderate effect size, and $r \geq .50$ indicates a large effect size.

actively engages oppressed communities like GBTY in 3 years. We believe the coalition could have benefited from additional time and resources. Furthermore, intergenerational partnerships must address adult–youth power dynamics. While some Steering Committee and University members had experience working with youth, YAB members sometimes members felt overshadowed by adults.

Evaluating PSE change interventions presents another set of challenges. First, structural change often becomes evident only after a longer period of time than most grant timelines allow. By the time the PSE intervention was developed and implemented, a 6-month postintervention assessment was the furthest follow-up available, which may have missed subsequent PSE changes.

Strengths

Despite these challenges, MFierce maintained stable domains of coalition dynamics related to CEJ principles over the 3-year project. Despite challenges, we believe our collaborative, shared-power approach allowed members to effectively and positively contribute to the collective HAI efforts.

In-depth interviews and surveys allowed us to continually improve the quality of member experiences. As our understanding of the facilitators to YAB participation grew, we focused more time and resources on these factors including compensation, food, transportation support, personal and professional development, and fostering the YAB's sense of influence on the project. We believe this extra effort was instrumental in YAB members gaining skills, building relationships, developing personally and professionally, and being recognized as community leaders.

MFierce created an effective PSE change program that helped clinics create more affirming environments for GBTY to receive care. Coalition members felt it was important to make our program materials accessible to the community, and we have made dozens of products available for free on our website including HAI training materials and an array of

digital and print resources. At the time of writing this article, an expanded version of the HAI has received additional funding to continue implementation.

Implications for Practice

We present recommendations for developing and maintaining intergenerational, collaborative, multisector partnerships that prioritize leadership by youth who are most affected by injustice and inequity. We also find these strategies to be critical in employing a shared-power community development process focused on improving health inequities among youth. Since we prioritized leadership by GBTY, the following strategies privilege our actions and experiences with the YAB.

1. *Facilitate iterative discussions on roles and responsibilities*. Since changing project needs necessitated shifts in coalition members' tasks, iterative discussions on roles and responsibilities helped reduce role ambiguity, especially within the YAB. We recommend facilitating discussions with members early on about the phases of the project and how responsibilities will change over time.
2. *Ensure transparency in decision making*. Transparency in decision making with coalition members was vital to maintaining trust. We recommend ensuring that members understand decision-making processes and roles early on and throughout the project.
3. *Provide appropriate pay and capacity development for youth members*. Hourly pay and other incentives supported the YAB's ability and motivation to be involved and reduced barriers to participation. We recommend providing appropriate compensation, incentives, education, and professional development opportunities to youth members.
4. *Provide training on collaborative intergenerational dynamics for adult members*. We realized more training on collaborative, intergenerational processes could have provided adult members with knowledge and skills related to adult-youth dynamics and developmental needs of youth. We recommend providing education early for adults on how to effectively and respectfully work with youth.
5. *Use varied decision-making techniques that provide opportunities to be heard.* Using multiple decision-making techniques, including consensus and voting in small and large group processes, created an overall, smooth intervention development process where power is shared among members. We recommend adjusting decision-making techniques over time to support members feeling heard, involved, and influential in the project.
6. *Address sources of fluctuating youth involvement in a flexible manner*. When working with youth, expect that their capacity to be involved may waver. We recommend creating additional time for youth to complete tasks and open communication about their needs, and building flexibility into the process to enhance youth participation.
7. *Let youth narratives direct intervention development and implementation*. Through collaborative processes, youth members were able to share their lived experience and directly determine the intervention, educational resources, and presentations that would affect their communities. We recommend allotting resources to involve members of the priority communities in projects intended to impact their communities.
8. *Provide opportunities and training for active involvement in dissemination activities.* Contributions to scholarship should include members of the priority community in order to improve accuracy of our understandings, offer a platform for community members to share lived experience, and provide leadership and professional development. We recommend devoting time and resources to ensuring that coalition members, especially youth, are provided with capacity-building skills to fully participate in these dissemination processes.

Using CEJ principles for collaborative practice, MFierce used participatory methods to center GBTY in the development, implementation, and evaluation of an impactful PSE intervention. Through a shared-power community development process, our intergenerational, collaborative, multisector coalition has uplifted GBTY narratives and lived experiences. By supporting GBTY personally and professionally, MFierce prioritized the leadership of those most affected by injustice and inequality to be active leaders in bringing about change in their own communities.

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